FAX to: TDMH- Crisis Services (615) 253-6822
OR E-mail to MPA.Info@tn.gov

# REGISTRATION
# MANDATORY PRE-SCREENING AGENT TRAINING

**Please Print**

**Requested Training Date (see training announcement for dates)** _____

**Name (as listed on your license):** _____

**Agency (if applicable):** _____

**Business Address:** _____

_____

**Business Phone:** (_____)_____

**Business E-mail:** _____

**Home Address:** _____

_____

**Home Phone:** (_____)_____

**Home E-mail:** _____

**I am a (check all that apply):**

| | | |
|---|---|---|
| ☐ | Licensed physician with training, education, or experience in psychiatry | Expiration date: _____ |
| ☐ | Licensed psychologist designated as a health service provider | Expiration date: _____ |
| ☐ | Licensed psychological examiner | Expiration date: _____ |
| ☐ | Licensed senior psychological examiner | Expiration date: _____ |
| ☐ | Licensed master social worker (LMSW) with two years of mental health experience* (sign statement below) | Expiration date: _____ |
| ☐ | Licensed clinical social worker | Expiration date: _____ |
| ☐ | Licensed or certified marital and family therapist | Expiration date: _____ |
| ☐ | Licensed nurse with a masters degree in nursing who functions as a psychiatric nurse | Expiration date: _____ |
| ☐ | Licensed professional counselor | Expiration date: _____ |

*** As a licensed master social worker, I affirm that I have two (2) years of mental health experience.**

_____
LMSW Signature

**Signature:** _____ **Date:** _____

Revised August, 2011